

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-021283

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5913

STATE FILE NUMBER

FILED JUN 7 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4314 Lexington, Ave.		d. STREET ADDRESS (If outside, give location) 4314 Lexington, Ave.	

3. NAME OF DECEASED (Type or print) First Middle Last Daisy Barnes		4. DATE OF DEATH Month Day Year June 3, 1963	
5. SEX Female	6. COLOR OR RACE: Colored	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/17/1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. FATHER'S NAME John Davis		13b. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No Nil.		16. SOCIAL SECURITY NO. Mrs. Mae Ida Williams, 4325 Labadie, Ave.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 4200		INTERVAL BETWEEN ONSET AND DEATH During sleep
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from Feb 6 1963 to June 3 1963 and last saw her alive on May 10 1963	
Death occurred at 7:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) Charles Uleches MD	22b. ADDRESS 4067 Easton Ave	22c. DATE SIGNED 6/3/63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-9-63	23c. NAME OF CEMETERY OR CREMATORY Montrose Cemetery	23d. LOCATION (City, town, or county) Greenville, Illinois.
24. FUNERAL DIRECTOR Ripperdan Funeral Home, Mulberry Grove, Ill.		25. DATE RECD. BY LOCAL REG. JUN 4 1963	26. REGISTRAR'S SIGNATURE Joan Smith M.C.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

ITEM NO.

VS 300
Rev. 4/59

DATE AMENDED

INSTEAD OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Stanley H. Dixon

Licensed Embalmer No.

4193

P. O. Address

St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.